

**TRANSFER OF RESOURCES FOR LESS THAN FAIR MARKET VALUE (FMV)****I-1670**

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**TRANSFER OF RESOURCES FOR LESS THAN FAIR MARKET VALUE****I-1670****I-1671 GENERAL INFORMATION**

An individual who is applying for or approved for Long Term Care may not be eligible for payment of nursing home cost (vendor payment) if they, their spouse, or someone else acting on their behalf, gives away or sells an asset for less than the fair market value. In order for a, period of restricted coverage (called a penalty period), to apply the transfer must have occurred on or after a specific date (called the look back date).

An individual who is applying for or approved for Home and Community Based Waiver Services cannot be eligible for waiver (HCBS) services if they, their spouse, or someone acting on their behalf, gives away or sells an asset for less than fair market value on or after February 8, 2006.

The transfer of an asset for less than fair market value is presumed to be for the purpose of qualifying for Medicaid, unless the individual presents convincing evidence that the transfer was exclusively for some other purpose.

In all cases, the individual shall be offered the opportunity to rebut the presumption that a transfer was made to reduce assets in order to qualify for Medicaid. Convincing evidence must be provided which proves that the transfer was done solely for a reason other than to qualify for Medicaid.

For every case in which a period of restricted coverage (called a penalty period) is determined, the individual must be given the opportunity to apply for an undue hardship exception. Refer to Undue Hardship H-860

The Medicaid eligibility determination is made according to the policy in effect at the time of application or at application for institutional coverage and the date of the transfer.

**Note:**

Refer to I-1660, Spousal Impoverishment Resource Provisions, for transfers to a community spouse by an applicant/enrollee who entered a facility on or after September 30, 1989.

**I-1672 DEFINITIONS REGARDING TRANSFERS**

The following definitions apply to both transfer of assets and trusts:

**Assets** – Assets refer to all of the income and resources belonging to the individual and the individual's spouse. Assets also include income or resources which the individual or their spouse is entitled to but does not receive because of any action by:

- the individual or spouse;
- a person, including a court or administrative body, acting at the direction or upon the request of the individual or their spouse.

Assets to which an individual or spouse is entitled to also includes assets that they would be or would have been entitled to if action had not been taken to avoid receiving the assets.

The following are examples of actions which would cause income or resources not to be received:

- irrevocably waiving pension income;
- waiving the right to receive an inheritance;
- not accepting or accessing injury settlements; and
- court settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff.

**Compensation** – Compensation is all money, real or personal property, food, shelter, or services received at or after the time of transfer in exchange for a resource.

**Fair Market Value (FMV)** – Fair Market Value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in appraising the value for the purpose of determining Medicaid eligibility.

**Note:**

For an asset to be considered transferred for FMV or to be considered to be transferred for valuable

consideration, the compensation received for the asset must be in a tangible form with intrinsic value. For example, a transfer for love and consideration is not considered a transfer for fair market value.

**For the Sole Benefit of** – This phrase means to benefit one person only. A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

A trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future.

The transfer or trust instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved.

**Income** – The same definition used by the Supplemental Security Income (SSI) program. A gain or recurrent benefit measured in money.

**Individual** – the term individual includes the individual himself or herself, as well as:

- the individual's spouse, where the spouse is acting in place of or on behalf of the applicant;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- any person, including a court or administrative body, acting at the direction of or upon the request of the individual or the individual's spouse.

**Institutionalized Individual** – the term 'institutionalized individual' refers to one who is:

- an inpatient in a nursing facility;
- an inpatient in a medical institution for whom payment is

based on a level of care provided in a nursing facility; or

- a home and community-based services enrollee.

A medical institution includes an intermediate care facility for an individual with a developmental disability ICF/DD).

**Intrinsic Value** – Intrinsic Value is something that has value in and of itself (i.e., property).

**Look-Back Date (Period)** – The look-back date is the earliest date on which a penalty for transferring assets for less than fair market value can be assessed. Penalties are assessed for transfers that take place on or after the look-back date.

### **Transfers prior to February 8, 2006**

The look-back date for transfers occurring prior to 2-8-2006 for an institutionalized individual is 36 months prior to the baseline date. The baseline date for transfers occurring prior to 2-8-2006 is the first date of which the individual was:

- institutionalized; and
- applies for medical assistance under the State plan.

For a Medicaid recipient who becomes institutionalized, the baseline date is the first day of institutionalization.

### **Transfers on or after February 8, 2006**

The look back date for transfers occurring on or after 2-8-2006 is 60 months prior to the baseline date. The baseline date for transfers occurring on or after 2-8-2006 is the date an individual applies for Medical assistance and is determined eligible except for the occurrence of the transfer.

The look-back date is extended to 60 months when an individual establishes a trust and a portion of the trust is treated as a transfer for less than fair market value. The look-back period is 36 months disbursements which could be made to or for the individual but are made to another person.

Transfers of assets during the look-back period as well as transfers which occur after the baseline date are subject to penalty if they are made for less than the fair market value.

**Non-Excluded Resource** – A non-excluded resource is any resource

which would have counted, in whole or in part, toward the resource limit, if the resource had been retained. The excludability status of the resource at the time of transfer or contract for sale controls how to treat the resource when applying transfer penalties.

**Prohibited period** – This period is defined as anytime during or after the 36 months (60 months for transfers on or after 2-8-2006) prior to institutionalization (if the individual is entitled to medical assistance under the State Plan on that date), or, if the individual is not entitled on the date of institutionalization, the date the individual applies for assistance while institutionalized.

**Resources** –Resources are cash or other liquid assets or any real or personal property that an individual (or spouse) owns and could convert to cash to be used for his/her support and maintenance. The term resources for purposes of exclusions is consistent with Supplemental Security Income (SSI) program policy except the home and connecting land are not to be considered as exclusions from resources for institutionalized individuals.

**Spouse** – A spouse is a person who is considered legally married to an individual under the laws of the State in which the individual is applying for or receiving Medicaid.

**Uncompensated Value** –Uncompensated Value is the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages or other encumbrances on the resource), and the amount received for the resources.

**Valuable Consideration** – Valuable consideration is when an individual receives in exchange for his or her right or interest in an asset some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred asset.

## I – 1673      **WHAT IS A TRANSFER? TRANSFERS DEFINED**

Transfers of resource ownership may occur through any of the following types of transactions:

- sale or purchase of personal/real property;
- trade or exchange of one property for another, including purchase; or
- giving away property.

Indications that a transfer of ownership may have occurred include, but are not limited to:

- an individual's allegation of transfer; or
- other evidence (e.g. an IRS alert, bank statement, property clearance, etc.).

Obtain the individual's signed statement as to:

- the nature of the transfer (whether the resource was sold, given away, exchanged for goods or services, etc.);
- the method of transfer (whether the property was listed with an agent and sold, transferred without financial consideration, disposed of through purchase(s), etc.);
- the date of the transfer;
- a description of the property;
- the amount of cash transferred or estimated current market value (CMV) of other property;
- the amount of consideration received, if any (whether there were proceeds and their value, additional consideration expected and when); and
- any remaining ownership interest (e.g., a partial interest).

Obtain copies of available evidence of the alleged transaction. This includes items such as bills of sale, statements of purchase, receipts, or corroborating statements from recipients of gifts.

Document the decision concerning the validity of the transfer and the basis for it in the Medicaid case record. If the property (or share of property) whose ownership has been transferred no longer belongs to the individual (former owner), a transfer has occurred. If the property is still owned by the alleged "former" owner, no transfer has occurred.

Consider transfers made by:

- the applicant/enrollee,
- the Medicaid eligible spouse of the applicant/enrollee, except as allowed under Spousal Impoverishment provisions (Refer to I-1666),

- a representative acting for and legally authorized to execute a contract for the applicant/enrollee and

For example:

- a legal representative,
  - a parent of a minor child,
  - a holder of power of attorney, or
  - a curator
- the co-holder of an asset jointly held with the applicant/enrollee.

#### **I-1673.1 Transfers of Resources May Include:**

- establishing a trust or annuity,
- disposing of liquid and non-liquid resources,
- disposing of resources which could be received but are refused (e.g., having constructively received funds paid directly into a trust or refusing an inheritance),
- the purchase of Life Estate/Usufruct interest – the purchase of Life Estate Interest in another individual's home may be a transfer of resources if the FMV was not received and the purchaser did not actually reside in the home for a period of one year after the purchase of the Life Estate/Usufruct.

The transferred asset is the entire amount used to purchase the life estate if the applicant/enrollee never actually resided in the home of the Life Estate Interest or resided in the home for less than one year. The amount of the transferred asset may not be reduced or prorated to reflect an applicant/enrollee's residency for a period of time of less than a year. The individual may allege that the Life Estate has value. However, this cannot be taken into consideration in determining Medicaid eligibility because the individual never lived in the home nor derived full benefit from the Life Estate.

The value of the Life Estate interest purchased in another individual's home should be counted as a resource in

determining Medicaid eligibility unless it can be exempt as the applicant/enrollee's home.

The value of the Life Estate Interest must be determined to establish if fair market value was received.

To establish the value of the Life Estate Interest use the following steps:

- Determine the current market (equity) value of the property to which the applicant/enrollee purchased the Life Estate interest.
- Refer to Z-1300, Usufruct and Remainder Interest Chart.
- Select the line for the age of the applicant/enrollee at the last birthday of the purchaser.
- Multiply the figure in the usufruct column for the age by the current market (equity) value of the property.
- The result is the Life Estate value.

Determine the amount transferred for less than Fair Market Value (FMV) using the following steps:

- Determine the Life Estate value (see above).
  - Subtract the value of the transferred asset.
  - The result is the amount transferred for less than Fair Market Value.
- Establishment of promissory notes, loans or mortgages is a transfer of assets unless all of the following criteria are met:
    - The repayment must be actuarially sound;
    - Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments;  
and

- The promissory note, loan or mortgage must prohibit the cancellation of the balance upon death of the lender.

The amount of the asset transferred is the outstanding balance of the note, loan or mortgage due as of the date of the individual's application for Medicaid.

The life expectancy chart at Z-1200 is used to determine if the repayment is actuarially sound.

### **I-1673.2 Do Not Consider the Following as a Transfer When Applying Policy:**

- transfers of resources for which the applicant/enrollee had no ownership interest,
- using a resource to repay a valid debt or make a purchase,
- valid loans made by an eligible individual or an eligible spouse (refer to I-1534, SSI-Related Income, Loans),
- transfers of funds which do not result in a change of ownership (e.g., an authorized representative holding and managing funds for an applicant/ enrollee as long as the funds are available to meet the applicant/enrollee's needs),
- removing an applicant/enrollee's name from a joint account following successful rebuttal that the applicant/enrollee is not owner of the resource, and
- transactions which render a resource inaccessible, but do not change the individual's degree of ownership of the resource. For example, an individual who jointly owns property with another individual can enter into an agreement with the joint owner not to sell the share without the joint owner's consent.

### **I-1673.3 Valid Loan/Valid Debt Defined**

A valid loan/valid debt is a legally binding agreement made in good faith.

Consider an informal loan (oral or written) as valid if it is binding under State law and includes:

- The borrower's acknowledgement of an obligation to pay;
- A time table and plan for repayment (e.g., borrower plans to repay when he receives future anticipated income);
- The borrower's statement of intent to repay either by pledging real or personal property or anticipated income.

Relatives and family members legitimately can be paid for care they provide. However, it is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. Tangible evidence in the form of a copy of the payback arrangement that had been agreed to in writing at the time services were provided and ensuing payment records are required to rebut this presumption.

Note: Loans to family members must be in the form of a written agreement at the time the loan originated and meet the above conditions.

Obtain from the debtor a written statement as to the nature, amount, repayment arrangements and other conditions surrounding the alleged debt.

Obtain from the creditor a written statement as to the nature, amount, repayment arrangements, and other conditions surrounding the alleged loan.

Accept any documentary evidence offered to substantiate the debt and debt amount.

Determine whether the obligation definition components for valid debt listed above are met.

## **I-1673.10    Personal Care Agreements**

Personal Care Agreements (PCA) are contracts that allow an individual to pay another person to provide personal care services.

A Personal Care Agreement is valid only if all of the following are met:

- The agreement provides for the provision of reasonable and necessary medical care or assistance which is not otherwise covered by Medicare, Medicaid, or private insurance.
- The agreement must be in writing, and properly executed prior to the service or assistance being provided. The agreement cannot be applied retroactively to pay for services or assistance that was provided prior to the agreement.
- The agreement must specify the type, frequency, and time to be spent providing the services or assistance.
- The agreement must provide for payment upon rendering of the services or assistance, or within thirty (30) days thereafter.
- The agreement must be supported by evidence that payments were made in accordance with the agreement.
- The caregiver cannot be the spouse or parent of the applicant/enrollee.
- The applicant/enrollee or his or her legally authorized representative has the power to modify, revoke or terminate the agreement.

A Personal Care Agreement that fails to contain any of the mandatory provisions is considered to be invalid. Payments that are not considered to be compensation in accordance with a valid written agreement are transfers without compensation.

If a valid written agreement exists, it must be determined whether adequate compensation in the form of services or assistance was provided.

Adequate compensation shall be measured against rates paid in the open market for the service or assistance that was provided. If services or assistance require extraordinary skill, the provider or caregiver must possess the required skill, experience or expertise. These services or assistance may be valued in accordance with similar services in the community.

If payments are made for compensated services or assistance but the payments exceed the allowed value of the services or assistance, then the amount of the payment is a transfer without compensation.

The services and assistance must be provided within thirty days from the date of payment. Pre-payment for services or assistance not yet rendered and that cannot be provided within thirty days is a transfer without compensation.

The Personal Care Agreement ceases upon the death of the applicant/enrollee or upon admission to a nursing facility for more than 45 days.

#### **I-1674      EXCEPTIONS TO APPLICATION OF TRANSFER OF ASSET PENALTIES**

1. The asset transferred is the individual's home, and title to the home is transferred to the individual's:
  - spouse,
  - child who is:
    - under age 21, or
    - blind or permanently and totally disabled as defined by SSI at the time of the transfer.  
The age at onset of disability is not a factor.
  - sibling who has:
    - an equity interest in the home, and
    - who was residing in the home for a period of at least one year immediately before the date the individual became institutionalized.
  - child who:
    - is age 21 or over,
    - is not blind or permanently and totally disabled,
    - was residing in the home for at least two years immediately before the date the individual became institutionalized, and
    - provided care to the individual allowing the individual to reside at home, rather than in an institution.

**Note:**

The exception must be documented by written statement from physician indicating his/her knowledge that during the preceding two years, the individual's child was present in the home as the primary care giver and if not for the care provided by the child the individual would have required care in an institution or through HCBS.

2. The assets were transferred to the individual's:
  - spouse, or
  - to another for the sole benefit of the individual's spouse.
3. The assets were transferred from the individual's spouse to another for the sole benefit of the individual's spouse.
4. The assets were transferred to the individual's child, or to a trust established solely for the benefit of the individual's child who is blind or permanently and totally disabled as defined by SSI criteria. The child must be disabled at the time of the transfer. The age at the onset of disability is not a factor.
5. The assets were transferred to a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined by SSI.
6. The individual makes a satisfactory showing that he intended to dispose of the assets whether at fair market value or for other valuable consideration.
7. The individual establishes that the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

**I-1674.5      Annuities**

The purchase of an annuity by or for an individual using that individual's assets will not be considered under transfer of assets policy. The entire value of an annuity will be considered an available resource unless the criteria at Section I-1634.2 are met. This policy applies to annuities purchased with the applicant's own funds by the applicant/enrollee, spouse, guardian or legal representative and names the applicant /enrollee or spouse as the annuitant. Refer to Annuities in Section I-1634.2 to determine availability as a resource.

Transfer of resource policy will be considered when an applicant or enrollee's own funds are used to purchase an annuity for someone other than the applicant/enrollee or their spouse.

An annuity must name the State as the remainder beneficiary in the first position for the total amount of Medicaid assistance paid on behalf of the annuitant unless there is a community spouse and/or a minor or disabled child. If there is a community spouse and/or a minor or disabled child, the State may be named in the next position after those individuals.

If the State is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. The full purchase value of the annuity will be considered as the amount transferred.

### **Treatment of Annuities in Determining Eligibility**

The following types of annuities are not treated as a transfer of assets if the annuity meets the following conditions.

- a) The annuity is considered either:
  - (1) an individual retirement annuity (according to Section 408(b)) of the Internal Revenue Code of 1986 (IRC), or
  - (2) a deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408(q) of the IRC); or
- b) The annuity is purchased with proceeds from one of the following:
  - (1) a traditional IRA (IRC Sec. 408a); or
  - (2) certain accounts or trusts which are treated as IRAs (IRC Section 408 §(c)); or
  - (3) a simplified retirement account (IRC Sec. 408 §(p)); or
  - (4) a simplified employee pension (IRC Sec. 408 §(k)); or
- c) The annuity meets all of the following requirements:
  - (1) the annuity is irrevocable and non-assignable; and

- (2) the annuity is actuarially sound; and
- (3) the annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

Applicants or their responsible or authorized representative will be responsible for providing documentation from the financial institution for verifying qualifying IRS annuities. If documentation is not provided, the purchase of the annuity will be considered a transfer for less than fair market value and subject to a penalty. The full purchase value of the annuity will be considered the amount transferred.

When an annuity is determined to meet the requirements above and the purchase is not treated as a transfer, the transfer may be subject to a penalty if the annuity or income disbursed from the annuity is transferred, except to or for the spouse's sole benefit, to their child or a trust.

## **I-1675 UNCOMPENSATED VALUE**

The uncompensated value of a resource is the difference between:

- FMV at the time of transfer (less any outstanding loans, mortgages or other encumbrances on the resource), and
- the amount actually received for the resource.

The uncompensated value cannot exceed the amount that would have been counted if the resource had been retained.

To determine the uncompensated value, first determine the amount of compensation.

### **Determining Compensation**

Compensation is all money, real or personal property, food, shelter, or services received by the individual at or after the time of transfer in exchange for the resource.

Compensation includes items or services received by the individual prior to the transfer only if they were provided as a result of a binding contract between the parties involved. The contract must have been established at or before the transfer.

The contract must indicate that:

- the items are being provided in exchange for payment, and
- the transfer constitutes total or partial payment.

The value of the compensation is based on:

- the agreement,
- the expectation of the parties at the time of the transfer, and
- the form of compensation.

The value of compensation is the gross amount paid or agreed to be paid. The value is not reduced by expenses attributed to the sale.

### **Forms of Compensation**

Forms of compensation are valued as follows:

- Cash is valued at the total amount paid or agreed to be paid.
- Real or personal property is valued at the fair market value at the time of transfer.
- Support and/or maintenance are valued based on actual current market value and the length of time it has been and/or is expected to be provided.
- Services are valued at the market value of such services based on:
  - the frequency and duration, or
  - the usual and customary charges, if purchased from an outside source in that community.

If the service is transportation for shopping, visits to the doctor, etc., the value may be based on the local taxi fare charges. If the services are to be provided for the life of the individual, the total value is determined by using the Life Expectancy Table to determine the total value. Refer to Z-1200, Charts. Multiply the yearly fair market value of the services by the figure in the "Average Years of Life Remaining" column which corresponds to the age of the individual as of last birthday at the time the resource was transferred.

When compensation is made in the form of a service, the person who received the transferred resource must provide some verification such as:

- a written statement describing the service he or she agreed to perform, and
- the frequency and duration of such services.

If the services are to be provided on an as needed basis, the statement must include:

- the expectations as to the frequency of the services,
- a description of the agreement concerning compensation for services reached between the provider of the service and
- the basis for that expectation.

#### **I-1676 EFFECT OF UNCOMPENSATED VALUE ON ELIGIBILITY** (Determining the Penalty)

There is no penalty for individuals other than LTC/HCBS applicants/enrollees who transfer countable resources or home property for less than FMV.

The uncompensated value of a resource which was transferred for the purpose of establishing Medicaid eligibility (individual did not rebut presumption or rebuttal was unsuccessful) will be used to restrict Medicaid coverage to an otherwise eligible institutionalized individual.

#### **I-1676.1 Average Monthly Cost for Private Patients of Nursing Facility Services**

For applications on or before October 31, 2007 use \$3,000 as the average monthly private pay cost.

For applications on or after November 1, 2007 use \$4,000 as the average monthly private pay cost.

When a transfer is done on a certified case use the average monthly private pay cost at the time of transfer. For transfer of a certified case made on or before October 31, 2007 use \$3,000.00. For transfers made on or after November 1, 2007 use \$4,000.00.

**I-1676.2 Transfers Prior to 2-8-2006**

For transfers occurring prior to 2-8-2006, the look-back period is 36 months. The State must look at the uncompensated value of transfers occurring during the 36 month period before application for Long Term Care coverage and any time thereafter.

In all cases, the individual shall be offered the opportunity to rebut the presumption that a transfer was made to reduce assets in order to qualify for Medicaid. Convincing evidence must be provided which establishes that the transfer was solely for a reason other than to qualify for Medicaid.

The individual shall be given the opportunity to apply for an undue hardship exception in every case that a penalty will be assessed.

**Look-Back Period**

For an institutionalized person or person receiving HCBS the look-back date is the 36 month period prior to the month of application for Medicaid, starting with the baseline date. Penalties are assessed for transfers that take place on or after the look-back date. The baseline date is the first date the individual was:

- institutionalized; and
- applies for medical assistance under the State plan.

For a Medicaid enrollee who becomes institutionalized, the baseline date is the first day of institutionalization.

**Penalty Period Begin Date**

The penalty period for transfers prior to 2-8-2006 begins the month of the transfer and extends until the total uncompensated value of the transferred assets has been depleted. The penalty period is determined by dividing the uncompensated value by the average monthly cost to private pay patients of nursing facility care at the time of application for LTC/HCBS services and rounding down. There is no partial month penalty. Refer to I-1676.1 Average Monthly Cost for Private Pay Patients of Nursing Facility Services.

**Example:**

Individual transfers property valued at \$10,000.00 on October 5, 2005. The individual applies for and is found eligible for Medicaid June 20, 2006 except for the transfer. It

is determined that the individual is ineligible for 3.34 months ( $\$10,000.00/3000.00=3\text{months}$  and  $\$1000.00$  left over). The remainder would be dropped unless another transfer occurred before the penalty was exhausted. The penalty will begin October, 2005 and go through December, 2005. The penalty was exhausted prior to application.

When multiple transfers have occurred in different months and the penalty periods overlap, the uncompensated value for all the transfers is totaled and divided by the average monthly private pay rate at the time of application, and the penalty period begins with the month of the first transfer. Should another transfer occur (or be discovered) after a penalty has already been assessed, recalculate the penalty period. If penalty periods overlap they will be served consecutively, not concurrently.

**Example:**

Application for LTC filed April, 2007. During 2005, an individual transfers \$15,000 in January, \$15,000 in February, and \$15,000 in March, all of which are uncompensated. Calculated individually, based on the average monthly private pay rate of \$3,000 a month at the time of their application, the penalty for the first transfer is from January through May, the second penalty period is from February through June, and the third is from March through July. Because these periods overlap, calculate the penalty period by adding the transfers together (\$45,000) and dividing by the average monthly private pay rate of \$3,000 at the time of their application. This yields a penalty period of 15 months, which runs from January 1, 2005 through March 31, 2006.

How does a transfer penalty affect eligibility for LTC vendor payment and HCBS waiver?

When a transfer penalty must be assessed for a facility resident, the penalty applies only to the LTC vendor payment and does not apply to the Medicaid eligibility determination. The person will be eligible for all Medicaid services except LTC vendor payment.

When a transfer penalty must be assessed in an HCBS waiver case, the individual will be totally ineligible for Medicaid during the penalty period unless he/she can be certified in another Medicaid program.

Prior to DRA enactment, February 8, 2006, the applicant/enrollee in a HCBS waiver case was totally ineligible for Medicaid during the penalty period unless he/she could be certified in another Medicaid

program. The penalty period began the month of transfer and the applicant/enrollee could eventually gain HCBS eligibility after the penalty period was over.

With the enactment of DRA the penalty cannot begin until a person is eligible for Medicaid, except for the penalty. To be determined eligible for Medicaid HCBS waiver applicants must actually receive a waiver service. When you combine this condition of eligibility with the change in the penalty period start date, it becomes impossible for the penalty period to begin for a HCBS waiver applicant because they are not eligible for and receiving Medicaid services, except for the penalty.

### **I-1676.3 Transfers on or After February 8, 2006**

The Deficit Reduction Act of 2005 (DRA 2005) incorporated new requirements for treatment of transfers of assets for less than fair market value.

For transfers occurring on or after February 8, 2006, the look back period is 60 months (five years). The State must explore uncompensated values of transfers occurring during the 60 month period before application for institutional coverage and anytime thereafter.

States are required to impose partial month penalties for transfers that are less than the States average monthly cost for private patients of a nursing facility. If a transfer results in a partial month penalty, the penalty must be served.

When transfers occurred in more than one month during the look back period, multiple transfers may be combined to impose a single penalty period.

In all cases, the individual shall be offered the opportunity to rebut the presumption that a transfer was made to reduce assets in order to qualify for Medicaid. Convincing evidence must be provided which establishes that the transfer was solely for a reason other than to qualify for Medicaid.

For every case in which a penalty will be assessed the individual shall be given the opportunity to apply for an undue hardship exception.

#### **Look-Back Period**

Under the Deficit Reduction Act of 2005 (DRA 2005). the look-back date for an institutionalized person or person receiving HCBS is the 60

month period prior to the month of application and eligibility for Medicaid except for the transfer. Penalties are assessed for transfers that take place on or after the look-back date. The look-back date begins with a baseline date which is the first date as of which the individual was:

- institutionalized; and
- applies for medical assistance under the State plan and is found eligible except for the transfer.

For a Medicaid recipient who becomes institutionalized, the baseline date is the first day of institutionalization.

### **Penalty Period Begin Date**

The penalty period for assets transferred on or after February 8, 2006 for less than fair market value begins the month the applicant is determined eligible for Medicaid except for the transfer of resources.

#### **Example:**

The individual applies for and is found eligible for Medicaid November 20, 2007 except for the transfer. Individual transferred property valued at \$15,000.00 on March 1, 2006. A penalty period must be calculated and a penalty assessed. For applications on or after November 1, 2007, \$4000 is used as the average monthly private pay cost.

It is determined that the individual is ineligible for 3.75 months (Value of Transfer: \$15,000.00, divided by average monthly private pay rate:  $\$4000.00 = 3\text{ months}$  and \$3000.00 remaining).

The penalty will begin November 20, 2007 and continue for 3.75 months. The remainder (\$3000) will be used to calculate a partial month transfer penalty (.75 of a month). See next example for this computation.

If the individual is certified for Medicaid at the time of the transfer the penalty begins the first day of a month following the agency's first opportunity to provide an advance notice of vendor payment closing for facility residents or closing of case for HCBS.

#### **Example:**

If an individual is receiving LTC services and reports a transfer, the penalty will begin on the first day of the month after the advance notice expires.

Under Deficit Reduction Act of 2005 (DRA 2005) penalty periods are not to be rounded down to prevent partial month penalties. Partial month penalties are determined by dividing the amount transferred by the average monthly cost of nursing facility care (Refer to I-1676.1) and using the remainder divided by the average daily rate to determine the partial month.

**Example** (Calculating a Partial Month Penalty):

In the above example the client is ineligible 3.75 months (3 months with \$3000 remaining). To determine the partial penalty, calculate the number of days that will be included in the partial month. The average daily cost of nursing facility care is calculated by multiplying the monthly private pay cost \$4000, by 12 and dividing by 365. ( $\$4000 \times 12 = \$48,000 / 365 = 131.51$ ) Using the daily cost, \$131.51, divided into the remainder, \$3000 to determine the number of days ( $\$3000.00 / 131.51 = 22.82$  days).

The total penalty would be 3 months and 22 days. The client applied November 20, 2007 and was found eligible except for the transfer. The penalty would begin November 20<sup>th</sup> and run until March 12<sup>th</sup>, eligibility would begin March 13<sup>th</sup>.

For individuals already receiving Medicaid the penalty would begin the first of the month following the expiration of the advance notice and extending 22 days into the 4<sup>th</sup> month with eligibility beginning on the 23rd of the month.

Once a penalty period has begun to run, it continues until expiration. The penalty period does not start and stop with a person's need or receipt of LTC services.

**Example:**

An individual enters a nursing facility and is determined eligible for Medicaid, but a transfer of assets has occurred. The penalty period is determined to be for 6 months. Three months into the penalty, the individual discharges from the facility and returns to the community and their Medicaid ends. Five months later the individual enters a nursing home, applies for Medicaid, and is found eligible. Medicaid will pay for their care as the penalty has expired.

Penalties for a penalty period that has expired are not to be imposed for any eligibility period after the expiration date of the penalty. For transfers of assets not reported or discovered until the penalty period would have expired, the state is limited to recovery of costs for any past eligibility periods. A recovery referral should be submitted.

When a spouse transfers an asset that results in a penalty for the individual, divide the penalty between the spouses when:

- the spouse is eligible for Medicaid;
- a penalty could, under normal circumstances, be assessed against the spouse, i.e., the spouse is institutionalized; and
- some portion of the penalty against the individual remains at the time the above conditions are met.

**Example:**

Mr. Smith enters a nursing facility and applies for Medicaid. Mrs. Smith transfers an asset that results in a 36 month penalty against Mr. Smith. Twelve (12) months into the penalty period, Mrs. Smith enters a nursing facility and becomes eligible for Medicaid. The penalty period against Mr. Smith has 24 months to run. Because Mrs. Smith is now in a nursing facility, and a portion of the original penalty period remains, you must divide the remaining 24 months of penalty between Mr. and Mrs. Smith.

When one spouse is no longer subject to a penalty (e.g., the spouse no longer receives nursing facility services, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

In the above example, assume the 24 month penalty period was divided equally between Mr. and Mrs. Smith. After six months, Mr. Smith leaves the nursing facility, but Mrs. Smith remains. Because Mr. Smith is no longer subject to the penalty, the remaining total penalty (12 months) must be imposed on Mrs. Smith. If Mr. Smith returns to the nursing facility before the end of the 12 month period, the remaining penalty is again divided between the two spouses.

**I-1677**

**RECEIPT OF ADDITIONAL COMPENSATION**

If the applicant/enrollee alleges that additional cash compensation (not part of the transfer agreement) has been received, obtain:

- the applicant/enrollee 's statement giving the date, amount, and circumstances of the additional compensation, and
- the statement of the person paying the additional

compensation, or

- other documentary evidence.

Reduce the verified uncompensated value counted as of the date the additional compensation is received by the value of the additional compensation received. Recalculate the period of restricted coverage, if applicable.

## I-1678

### RETURN OF TRANSFERRED RESOURCES

When the applicant/enrollee alleges that an uncompensated transferred resource has been returned, obtain the following:

- applicant/enrollee/responsible person's written statement concerning:
  - the date and circumstances of return, and
  - what, if anything, was paid for the return of the resource, and
- documentary evidence of the return, if available, or a statement from the person who returned the resource.

**Do not continue** to count the uncompensated value of a transferred resource if the original resource is returned.

If **all** assets are returned to the individual, no penalty can be assessed. If a penalty has been assessed and payment for services denied, a return of the assets requires a retroactive adjustment back to the beginning of the penalty period. \*\*

The returned assets must be counted in determining eligibility during the retroactive period. Counting the returned assets as if the individual retained them during the retroactive period may result in the individual being ineligible for some or all of the retroactive period.

Assets returned to the individual must be considered when determining eligibility, including eligibility for the period between the initial transfer penalty period and the date of the return.

If only a part of the asset or its equivalent value is returned, the penalty period is modified, but not eliminated. In the case of a partial return of assets transferred on or after February 8, 2006, the month the penalty period begins will need to be adjusted to the month the applicant is determined eligible for Medicaid except for the transfer

of resources.

**Example:**

Applicant for LTC is determined eligible for Medicaid on October 1, 2008. However, a transfer of property valued at \$70,453.00 occurred on September 1, 2008. A transfer of resource penalty was applied and the applicant was ineligible for vendor payment for 17 months and 18 days beginning March 19, 2008. On September 01, 2009, it was reported that \$23,000.00 of resources were returned to the individual in August, 2009. The returned resources were used to pay the facility fee and his countable resources were below the resource limit as of September 1, 2009. The returned assets are counted as though the transfer of \$23,000.00 did not occur and were retained by the individual during the retroactive period. This resulted in the individual's resources exceeding the allowable resource limit until September 1, 2009. The penalty period should be recalculated using the un-refunded portion of the \$47,453 of the uncompensated transfer. Adjust the penalty period beginning September, 2009 as this was the month that the individual was determined eligible for Medicaid had it not been for the transfer of resources. The re-calculated penalty period of 11 months and 26 days begins September 1, 2009 with vendor payment beginning August 27, 2010.

**I-1679      REBUTTAL OF PRESUMED VALUE**

All cases involving a transfer of resources with any amount of uncompensated value require that the applicant/enrollee be offered an opportunity to rebut the presumption that the transfer was made to become Medicaid eligible or to qualify for LTC vendor payment.

Mail immediately BHSF Form 2-TR, Notification of Transfer of Resources Determination to the applicant/enrollee/responsible person advising him of:

- the amount of the uncompensated value,
- the period for which he will be ineligible for LTC vendor payments and/or HCBS, and
- his right to rebut the presumed reason for transfer within seven working days.

Also, notify the applicant/enrollee/responsible person in person or by telephone of the above information, if possible.

If the applicant/enrollee/responsible person makes no effort to rebut within seven (7) working days after the notification form was mailed, assume that the presumption is valid and determine the impact on eligibility.

Advise the applicant/enrollee/responsible person who wishes to rebut the presumption that it is his responsibility to present convincing evidence that the transfer was exclusively for another purpose.

The presence of one or more of the following factors may indicate that the resource was transferred exclusively for a purpose other than to qualify for assistance:

- If after the transfer the individual experienced:
  - an unanticipated, drastic change in his health which resulted in a greatly increased need for medical care,
  - the unexpected loss of other resources which would have made him ineligible for assistance, or
  - the unexpected loss of income which would have made him ineligible for assistance.
- The value of the transferred resource was less than the average private facility payment.
- The transfer was made as a result of a court order or other legal commitment.

### **Request for Rebuttal**

The applicant/enrollee/responsible person shall be asked to provide:

- a written statement rebutting the presumption, although any oral statement should be accepted and documented in the case record, and
- any relevant documentation (e.g., legal documents, realtor agreements, correspondence, statements from others involved in the transfer).

Statements shall include, but need not be limited to the applicant/enrollee's:

- purpose for transferring the resource,
- attempts, if any, to dispose of the resource at the Fair Market Value (FMV),
- reasons for accepting less than the Fair Market Value (FMV) for the resource,
- means of or plan for support after the transfer, and
- relationship, if any, to the persons to whom the resource was transferred.

### **Decision on Rebuttal**

Convincing evidence must be presented showing the specific purpose that the asset was transferred.

Consider all statements and documentation provided by the applicant/enrollee.

If it is determined that the applicant/enrollee had some other reason for transferring the resource but any expectation of establishing eligibility could reasonably be inferred to be a factor in the individual's decision to transfer the resource, the presumption that the transfer was exclusively for some other purpose is not successfully rebutted.

If the applicant/enrollee provides convincing evidence that the disposal was solely for some purpose other than to establish eligibility for Medicaid, the presumption is successfully rebutted. Establishing eligibility could reasonably be inferred to be a factor in the individual's decision to transfer the resource, so the presumption is not successfully rebutted if there is any suggestion of this.

Supervisory review and concurrence is required and shall be documented for all successful rebuttals.

If the supervisor is unable to reach a decision, refer a summary of pertinent facts to the Eligibility Policy Section in State Office for a decision.

### **Notification**

Send written notification of the decision to the applicant/enrollee or responsible person. Send notice of right to apply for an undue hardship exception. See H-860, Undue Hardship. After the undue hardship notice expires, a final notice of decision may be sent.